Review of the UNDP/DFID support to the National HIV/AIDS Response in Nepal

Report of a joint UNDP/DFID review held 21 January – 2 February 2007

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LIST OF ABBREVIATIONS

ANC	Ante Natal Care
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti- Retroviral Therapy
BDS	Blue Diamond Society
BSS	Behavioural Surveillance Survey
CBO	Community Based Organization
CCM	Country Coordination Mechanism
CSO	Civil Society Organization
DACC	District AIDS Co-ordination Committee
DDC	District Development Committee
DPHO	District Public Health Officer
EDP	External Development Partner
FHI	Family Health International
FPAN	Family Planning Association of Nepal
FSW	Female Sex Worker
GFATM	Global Fund to Fight against AIDS, Tuberculosis and Malaria
GON	Government of Nepal
HIV	Human Immunodeficiency Virus
IBBS	Integrated Bio-Behavioural Survey
IDP	Internally Displaced Person
IDU	Injecting Drug User
IEC	Information, Education and Communication
ILO	International Labour Organisation
INGO	International Non-Governmental Organization
M&E	Monitoring and Evaluation
MARP	Most At Risk Population
MDG	Millennium Development Goal
MoHP	Ministry of Health and Population
MSA	Management Support Agency
MSM	Men who have Sex with Men
NAC	National AIDS Council
NACB	National AIDS Control Board
NACC	National AIDS Coordination Committee
NANGAN	National NGO Network Group against AIDS Nepal
NAP+N	National Association of PLHA in Nepal
NCASC	National Centre for AIDS and STD Control
NGO	Non-Governmental Organization
OI	Opportunistic Infection
PMTCT	Prevention of Mother to Child Transmission
PMU	Project Management Unit
PR	Principal Recipient
PRSP	Poverty Reduction Strategy Plan
RFP	Request for Proposals
STI	Sexually Transmitted Infections
SWAN	Sex Workers' Association of Nepal
UNDAF	UN Development Assistance Framework
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

Executive Summary

The HIV/AIDS epidemic is driven by risk behaviours such as unprotected sex especially in the context of sex work and male – to - male sex, injecting drug use facilitated by high mobility especially to India. There is considerable diversity in prevalence rates and intensity of response to the epidemic.

The response of the Government of Nepal is managed by the National Centre for AIDS and STD Control (NCASC) which functions as a vertical disease control programme unit under the Directorate of Health Services. This arrangement takes away the flexibility in financial management, staffing norms and management practices needed to work with civil society. There has not been much success in mainstreaming AIDS control into other sectors or in involving local administrative bodies. The structure is currently under examination by GON. More than 95% of the resources for AIDS programming are provided by EDPs. However there is no mechanism to coordinate their inputs, which impacts on effectiveness of aid. EDPs implement most of their programmes through NGOs, CBOs, civil society networks and the private sector. Networks attend to the capacity building needs of CBOs.

Nepal has seen two five-year strategies implemented and the third one (2006-11) is at the draft stage. A national costed action plan has also been developed for 2006-2008. Existing programmes focus on populations most at risk of infection and on treating persons who are infected. An increasing proportion of MARPs are being reached with prevention services except in western districts. Among health sector related interventions there are 65 VCT centres, 7 ART sites and 7 PMTCT centres.

Among the challenges faced by the national response are the lack of data to track a dynamic epidemic, systems for internal and external quality assurance, lack of linkages with other service providers such as TB and reproductive health services, formalisaton of the role of civil society organisations and networks, better coordination at national and district level between different implementing partners and a lack of leadership by the national government. Restructuring the NCASC is a necessary condition for assumption of leadership and coordination by national government.

The DFID funded programme on HIV/AIDS used the UNDP Management Support Agency (later converted to a Progamme Managment Unit) set up to manage the GFATM grant. DFID contributed USD 4.4 million to the programme in 2005 and by another agreement in 2006 contributed USD 6.9 million. Two implementation modalities were agreed upon for the DFID funded programme: the first was ‘RFP’ (Request for Proposals) for more established NGOs working on migration issues, and the second process combined Fast Track and Challenge Funds, aiming to support interventions for high risk populations by less established NGOs and community groups based on a criteria established by a stakeholder group and Challenge Fund managed by NAP+N who provided small grants to community based organisations. The processes involved in selection have been well documented.

The GFATM and DFID funded programme had set up 119 projects delivered by 77 NGOs in 27 districts by 2006. The activities implemented range from information and awareness; peer education; VCT and STI services; harm reduction; rehabilitation;

and care and support to people living with HIV/AIDS and safe blood supply. The services are primarily provided to mobile populations and their families; young people; IDUs; people living with HIV/AIDS, uniformed personnel, men having sex with men and sex workers to reduce their risk of HIV/AIDS infection.

The programme has ensured that interventions have been grounded fast and services have been made available to the target group. The NGOs acknowledge that DFID and MSA made available funds for grass root level work when funds for interventions with MARPS were drying up. The level of progress varies between different activities indicating that NGOs are responding to emerging needs rather than work according to a prior plan.

Some of the constraints of the DFID/UNDP HIV/AIDS programme are: the lack of standard operating guidelines and IEC materials, lack of a process of capacity building for NGOs, over representation of Kathmandu based NGOs even to manage projects in other districts and uneven distribution of interventions between districts. There have been complaints regarding contract, finance and procurement practices by UNDP. Contracts were signed long after starting date. There were delays in transfer of funds. Some of the goods procured by UNDP are delayed, are more expensive and inferior in quality to what NGOs could have obtained from the market. NGOs, while appreciating the staffing constraints of UNDP, desired to see more guidance and technical support.

Recommendations from the consultancy are addressed to the national programme in general, to DFID, and to UNDP: GON and EDPs should move towards a more suitable national institutional mechanism to lead the response. In the short term this should be a strengthening and restructuring of the NCASC to give it delegated powers of government than setting up a new entity. The restructuring should flow out of a national consultation and can be established by a cabinet order or an act of parliament. This should be preceded by an institutional appraisal of NCASC to determine the number and profile of the human resources required. There should be a mechanism to ensure coordination among the EDPs and government. There should be more transparency on funds, activities and programme performance of different partners including a consolidated report and annual review. The national programme needs a more comprehensive M&E system including a second generation surveillance system. The programme needs to formalise and enhance the role of civil society networks especially in capacity building. There is a need to institute internal and external quality control measures. EDPs should play a stronger role in advocacy for HIV/AIDS.

DFID should continue its ongoing support to the National HIV/AIDS Program executed by UNDP, provided a strong capacity building process can be integrated in the ongoing process. DFID should move to a more hands-on policy level engagement with the national programme to integrate HIV/AIDS with existing health programmes and strengthen donor-government coordination mechanisms. DFID needs to support GON in accessing and managing more resources as the resource gap for the current work plan is 47% and resources for the future are uncertain. DFID may have to be prepared to fill the gap after assistance from other donors has been accounted for. In future programmes DFID should advocate for the identification of NGOs and/or support the growth of new community based organisations in locations

where interventions have not happened. DFID should engage with government to create greater ownership and capacity so that they can take over management of the programme in the next cycle. This needs to be carefully managed and gradually executed so that the response does not diminish. DFID should help ensure that capacity building, which was identified as a major gap in the programme, becomes an integral part of the programme

UNDP should formalise systems for information sharing and greater involvement of NCASC in decision making. The programme should also provide more and better technical support to the projects it supports. Existing NGO networks can be supported to develop and execute national capacity building plan. UNDP should also put a system in place through which their staff can learn about the latest technical developments in HIV/AIDS, and disseminate it to NGOs. UNDP also needs to set up learning systems so that they can learn from experience gained by NGOs in the field. To ease the fund flow situation UNDP should pay implementing partners 6 months in advance, with subsequent quarterly instalment payable after approval of quarterly progress and expenditure reports. UNDP should identify reasons for delays in delivery of supplies and ensure timely procurement and delivery of supplies to NGOs. There should be more supporting / monitoring visits by UNDP staff so that NGOs receive adequate support and feedback in the field. UNDP, DFID and NCASC should ensure that District HIV/AIDS Coordination Committees (DACC) are given a formal role in endorsing or approving district-level interventions.

1. BACKGROUND

1.1 Introduction: about this review

In December 2006, DFID and UNDP agreed to undertake a joint review of the part of the national HIV program in Nepal funded by DFID and managed by UNDP. DFID needed to conduct an annual review of their support to the national response to HIV/AIDS and UNDP wished to review progress in implementation of its HIV related work and programmes, take stock of lessons learned, and identify gaps and potential areas for future support in Nepal.

DFID engaged a DFID HIV/AIDS advisor from within the region, and an independent HIV/AIDS expert. The UNDP team consisted of an independent HIV/AIDS expert and a member of UNDP's Regional Centre, Colombo HIV/AIDS Practice Team, who participated during the first five days of the review mission. Part of the review was conducted jointly and part separately by the DFID and UNDP consultants, working as two teams.

There were four main objectives of the review:

- an appraisal of the status of the national programme: in particular the effectiveness of the institutional arrangements and the adequacy of technical assistance provided to the national programme
- a review of DFID's role, especially its level of strategic engagement in policy issues – to be conducted by the DFID team members
- a review of the institutional arrangements in place to manage the HIV/AIDS programme, in particular a review of the efficiency and effectiveness of the UNDP HIV/AIDS management unit
- an assessment of UNDP's contribution to the national programme and potential additional areas for future engagement – especially viewed in the light of the recently completed Joint UN Programme on HIV/AIDS (2006-2011), the draft 2006-2011 National Strategic Framework as well as UNDP's global mandate as a UNAIDS cosponsor, including mainstreaming HIV/AIDS as a development issue in instruments such as the PRSP and District Periodic Plans, promoting enabling legislation, furthering human rights and gender – to be conducted by the UNDP team members

The methodology included a review of national level policy and programme documents, discussions with key national stakeholders (civil society, Government of Nepal, relevant donors and implementation organisations), a review of institutional arrangements, an analysis of documents from UNDP and relevant reports from implementing NGOs, existing evaluation reports, and interviews with a sample of implementing NGOs to ascertain their level of satisfaction and recommendations. Implementing partner organizations were visited in Kathmandu, Makwanpur, Rupandehi and Chitwan districts. The UNDP consultant had additional meetings with

implementing NGOs of two other UNDP projects to examine HIV mainstreaming in the field.

1.2 Status of the HIV/AIDS epidemic in Nepal

The first case of AIDS in Nepal was reported in 1988. Since then, the numbers of people with HIV/AIDS have risen steadily among the country's population of 27 million. As of May 2006 a total of 6,650 HIV positive cases were officially reported, with 2.6 times as many men infected as women. National level cumulative data show 1,047 cases of AIDS and 322 AIDS deaths reported. However, given the limitations of Nepal's public health surveillance system, the actual number of HIV infections is expected to be much higher.

Table 1. Estimates of size and HIV prevalence among Most At Risk Populations (MARPs), Nepal 2005

HIV rates in people who:	Average size estimate:	Median prevalence rates (2003)	HIV prevalence (%)		Average estimate of PLHA number:	Share of PLHA in total
			Min	Max		
Inject drugs	19850	38.4	21.9	43.5	6493	9
Have male to male sex	128500	0.8	1.6	2.3	2517	4
Engage in female sex work	29750	4.2	1.4	6.1	1118	2
Buy sex from sex workers	659000	2.10	0.9	3.2	13595	19
Migrate for work seasonally	1239000	NA	1.4	3.9	32341	46
Low risk Female (U)	943449	NA	0.10	0.30	1886	3
Low risk female (R)	5371335	NA	0.12	0.34	12306	18

(Source: NCASC (2006): "National Estimates of adult HIV infections, 2005)

As can be seen from Table 1. Nepal's epidemic has the characteristics of a concentrated epidemic, driven primarily by risk behaviours that drive other epidemics in the region: unprotected sex with multiple partners (specifically in the context of sex work and in male-to-male sex) and unsafe injecting drug use (IDU). Poverty, gender inequality and high mobility – seasonal labour migrants as well as cross-border migration, mainly to India – provide the background in which many of these behaviours occur. Injecting drug users, female sex workers and their clients, men who have sex with men and returning migrants have prevalence levels significantly higher than the general population. HIV prevalence among IDU dropped from 40% in 1999 to 38.4% in 2003 to 32.7% in 2005. At much lower levels are the prevalence among female sex workers and their clients and migrants. An important factor enhancing vulnerability to HIV is the high number of women who migrate or are trafficked to India to work – often in the sex industry. About 50% of Nepal's FSW

previously worked in Mumbai, India, and some 100,000 Nepalese women continue to engage in sex work there. It is estimated that 50% of Nepalese sex workers in Mumbai brothels are HIV positive (FHI 2004).

National aggregates mask the diversity in HIV prevalence between different regions in Nepal (Table 2). The comparatively higher prevalence levels in Kathmandu valley may be accounted for by the higher level of economic activity and its attraction for floating population from the rest of the country. But more significant are the higher prevalence levels in far western hill districts, especially as this region has not seen much prevention and treatment activities.

Table 2. HIV prevalence (%) among MARPs in different regions of Nepal

MARPs	Kathmandu Valley	Highway districts	Far western hill districts	Remaining districts
IDUs	47 - 57	12 – 42	10 -15	10-15
MSM	3.5 – 5.0	1.75 – 2.5	1.75 – 2.5	0.5 – 1
FSWs	2 - 15	1 – 3	3 - 5	1 – 3
Clients	0.67 - 5	1.2 – 2.7	1.5 – 2.5	0.5 – 1.5
Migrants	1.23 – 2.57	0.6 – 3.5	3.7 – 7.7	1.23 – 2.57
Female (U)	0.10 – 0.30	0.10 – 0.30	0.10 – 0.30	0.10 – 0.30
Female (R)	0.10 – 0.30	0.10 – 0.30	0.50 – 1.00	0.10 – 0.30

The 2006 Integrated Bio-Behavioural Survey (IBBS) revealed that (Table 3) most respondents in different sub-populations had heard of HIV/AIDS, though full awareness about transmission was low.

Table3. Results of IBBS among FSWs, Truckers and Migrants (2006)

MARPs	Heard of HIV AIDS	Full awareness about HIV/ AIDS*	Exposure to OE and PE†	% of Consistent condom Use with		Prevalence of any STI
				Clients/ FSW	Regular partners	
FSWs (Kathmandu Valley)	99.4	30	83	56	7	52 3 (Syphilis)
FSWs (High way districts	98	31	80	43	6	5(Syphilis) 10(Gon) 12(Chlamyd)
FSWs (Pokhara)	98	25	50	37	7	23 2 (Syphilis)
Truckers (East- West Highways)	100	50	12	71	3	10 2 (Syphilis) 1 (HIV)
Migrants (Western)	90	16 (West) 22(Mid-far	NA	65	5	8

* Aware of two main methods of prevention and rejecting three main misconceptions on transmission

† Received interpersonal communication on HIV/AIDS prevention from an outreach worker or a peer educator

		west				

Source (Integrated Bio-Behavioural survey – January to March 2005. FHI, Nepal Country office, Kathmandu)

Truckers were found comparatively better educated and practising risky behaviours less often than other populations at risk. Migrants have a greater tendency to practice unsafe behaviours in the host country than in Nepal.

In summary, Nepal has a low level epidemic with a concentration of HIV prevalence in key populations most at risk of HIV infection. Western districts see higher levels of HIV infection, but lower coverage with prevention, treatment and care efforts. The existing programmes have managed to make their primary stakeholders aware of the issue of HIV but not succeeded in passing on crucial information on effective methods of prevention, ensuring consistent condom use and generating demand for prevention services.

1.3 Existing coordination mechanisms, legislation and frameworks

National and district co-ordination bodies

The response of the Government of Nepal is managed by the National Centre for AIDS and STD Control (NCASC) which functions as a vertical disease control programme unit under the Directorate of Health Services, with oversight by the Ministry of Health and Population. The staffing, budget and decision making powers are those of a wing of a government department. While this arrangement may contribute to a sense of ownership of the response by the health department, it takes away the flexibility needed to respond to a dynamic epidemic driven by many issues beyond the reach of health department alone.

The NCASC is understaffed to manage the entire national response to HIV/AIDS effectively. Many of the technical staff have been appointed with funding from EDPs, especially GFATM and USAID. The difference in terms of employment between government and EDP appointed staff has led to divisions in the team, with a lack of clarity in roles and responsibilities. NCASC has seen frequent turnover of Directors, preventing continuity. This has stood in the way of effective, government led leadership and coordination of the national response to HIV/AIDS.

In 1992, Nepal established a multi-sector National AIDS Coordinating Committee (NACC) chaired by the Minister of Health, with representation from different ministries, civil society, EDPs and private sector. In 2002 a National AIDS Council (NAC) was established, chaired by the Prime Minister, to raise the profile of HIV/AIDS. The NACC reports to the NAC. The NAC was meant to set overall policy, lead national level advocacy, and provide overall guidance and direction to the national HIV/AIDS program. The NACC, on the other hand, was expected to oversee implementation of national policies and strategies, ensure technical quality and manage donor coordination. However, so far both the NAC and the NACC have not played the role they were expected to.

Nepal has a strong system of decentralised administration, in the form of District and Village Development Committees. Since HIV prevention efforts are best organised at the local level, every district has set up District AIDS Co-ordinating Committees

(DACC). Where committed and competent officials as well as support by active civil society NGOs are present, DACC plays a meaningful role. However the top down design of AIDS control programmes and lack of support for DACCs have made them peripheral actors in most district-level AIDS responses.

Recognising the weakness of the implementation machinery at national and district level, efforts have been made to reorganize them. An institutional reform task-force was established in May 2005. The government has also set up a core committee to examine the options proposed by the task force. Currently the government is considering recommendations of this committee. (World Bank, December 2006).

National policies and programmes

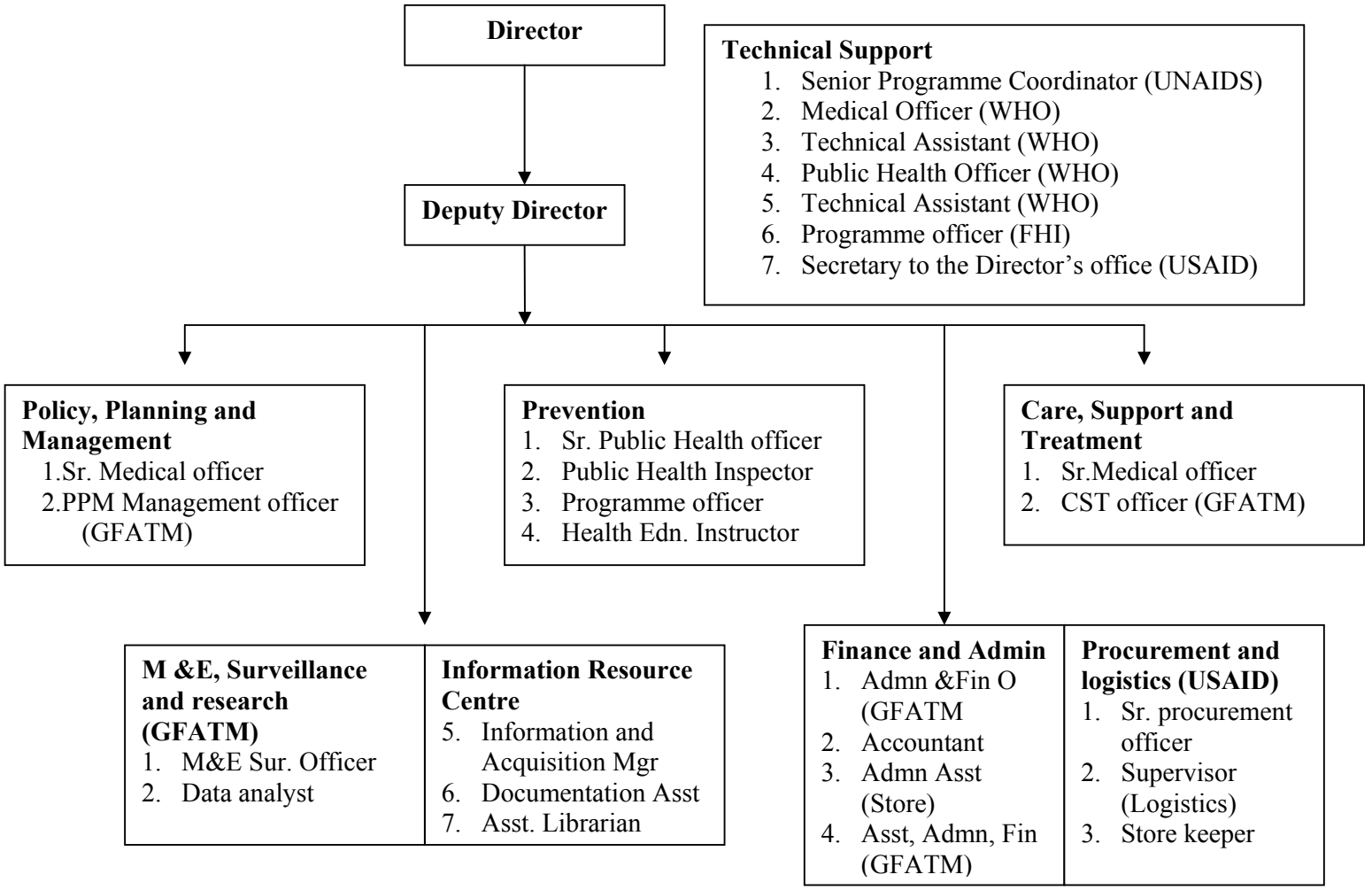
In 1988, the Government of Nepal launched its first National AIDS Prevention and Control Program. In 1995, a national policy was formulated. The first coordinated plan by the government was the Strategic Plan for HIV and AIDS in Nepal (1997-2001) followed by the National HIV/AIDS Strategy (2002-2006). Five priorities were identified for the Strategy (2002 – 2006):

i) Prevention of STIs and HIV among vulnerable groups,
ii) Prevention of new infections among young people,
iii) Ensuring care and support services are available and accessible for all people infected and affected by HIV/AIDS
iv) Expansion of monitoring and evaluation through evidence based effective surveillance and research
v) Establishment of an effective and efficient management and implementation mechanism for an expanded response.

Towards its implementation, a National Operational Plan for HIV/AIDS Control (2003 – 2007) was prepared, with an estimated budget of US$ 95 million for five years. The increase in international commitments to HIV/AIDS that happened during this period (especially the launch of the Global Fund against AIDS, TB and Malaria (GFATM)) ensured that larger amounts of funds were available year after year. Starting from USD 2.5 million in 2002-03, resources available increased to USD 5.4 million in 2003-04 and touched USD 14 million in 2005-06.

Nepal has developed, in consultation with major stakeholders, The National HIV/AIDS Strategic Plan (2006-11). The draft plan is being considered by the government. Based on the draft strategic plan, a national action plan and budget has been developed for 2006-2008. This has clear targets, budgets and costing norms. Allotment of resources focuses on prevention, especially among MARPs (42.5%) and youth (12.1%) with 15.4% allocated to treatment and impact mitigation. The allocation for management appears to be on the low side (13.9%) especially as it includes capacity building and M&E. Overall the allocation of resources is appropriate to the state of the epidemic. However given the resource gap of 47% the work plan may fall short of the scale of resources needed to reverse the epidemic.

Figure 1: Organogram of the National Centre for AIDS and STI Control



External development partners and mechanisms for donor coordination

External development partners (EDP) account for more than 95% of the resources committed to the national AIDS response in Nepal. (Table 4). Some agencies provide programme, management and technical support while most concentrate on programme support. Since government channels are not flexible enough to manage the EDP funds, most agencies directly execute the projects or have outsourced agencies to manage their grants. Execution in the field happens through civil society organisations or through the private sector.

Since most of the national response is managed by EDPs and since most of them are signatories to the UNAIDS 'Three Ones' principle, which aims to coordinate external developmental assistance on AIDS programming, it was expected that the EDPs would have arranged for proper coordination of their activities among themselves and with the government. However we could not find evidence of such coordination happening. Current institutions that have the potential to play such a role are:

Country Coordination Mechanism (CCM)

This body has met when ever required to meet the requirements of GFATM. But it has not engaged in coordination of the national response even though GFATM funding is to be regarded additional to other sources of funding for AIDS response. It is chaired by the Secretary of Health. The CCM has representatives from government ministries (Home Affairs, Law and Justice, Finance, Women and Social Welfare, Local Development, Information and Communication, Education and Sports, National Planning Commission, the Directorate of Health Services, the Institute of Medical Sciences); it includes professional associations (nursing, public health, industry, commerce, tourism); representatives of civil society (NANGAN, Nepal HIV AIDS Alliance, Harm Reduction Network, NAP+N) and EDPs.

Table 4. Share of pledges by EDPs in total resources for 2005/2006 National Work Plan: [Calculated from various documents of NCASC]

No.	EDP partner	2005		2006	
		Pledged (USD)	% share to total	Pledged (USD)	% share to total
	DFID	4,797,456	33.07	6,653,319	23.49
	USAID	4,739,924	32.67	10,155,486	35.86
	GFATM	2,621,315	18.07	6,931,000	24.48
	Nepal Red Cross	585,070	4.03	844,444	2.98
	AusAid	406,238	2.80	685,668	2.42
	FPAN	305,274	2.10	412,000	1.45
	UNDP	186,000	1.28	447,645	1.58
	UNICEF	182,500	1.26	650,000	2.30
	UNAIDS	172,000	1.19	288,000	1.02
	Nepal Government	146,657	1.00	540,000	1.91
	UNFPA	120,000	0.83	252,704	0.89
	WHO	100,000	0.69	100,000	0.35
	Other(EDPs, INGOs)	146000	1.01	358,000	1.26
	Total	**14,506,383**	**100**	**28,318,266**	**100**

UN Theme Group

The UN Theme Group operates in two different forms. In its first form, the UN Theme Group is composed exclusively of the co-sponsors of UNAIDS[‡]. This body approves the Joint UN plan on HIV/AIDS, monitors its implementation and ensures consistency with the UN Development Assistance Framework (UNDAF). Under its guidance, co-sponsors of UNAIDS implement components of the joint plan as per the division of labour in UN. This has met only two times last year.

UN recognises the need for "strong collaboration with various external stakeholders"[§] and has set up an expanded Theme Group to which AusAID, DFID, GTZ, JICA and USAID are invited. This is dysfunctional, a fact recognized by UNAIDS, which stated that "UN agencies will establish direct partnerships with their relevant counterparts in the implementation of the Joint UN Plan."

EDP coordination forum

The EDP coordination forum, which reviews implementation of commitments under the Nepal Health Systems Project, is a functional coordinating mechanism. But this forum does not discuss HIV/ AIDS related issues, even though prevention and treatment of HIV is one of the major tasks of the health department.

Informal arrangements:

The forum that provides a level of informal sharing of information between development partners on HIV is a monthly lunch meeting. It results in sharing information that partners would like others to know and the possibility of discussing issues that concern different partners. The informal nature of the forum is both its strength and weakness.

The pitfalls of not having a functional coordination mechanism are evident in the field. As a helpful matrix of HIV related responses in Nepal, prepared by UNAIDS, shows, some regions and districts are relatively well served whereas other districts especially in the western region, have very few services. Both UNICEF and UNFPA provide Youth Friendly Services. But UNICEF provided centres do not have access to reproductive health services. There are no systems by which programmes funded by one EDP can make use of excess capacity available in those provided by another. As the National M&E system becomes operational there may be an improvement at least in collection of relevant data, which could assist coordination. In view of the large gap in resources between what is planned for and pledged in the Action Plan (2006-08) Nepal needs to have a coordinating body of development partners for optimal utilisation of available resources. Ideally such a body should be led by the national government. But in the absence of such leadership the Joint Programme of UN Agencies can develop and manage a coordination mechanism.

[‡] UNDP, UNICEF, UNFPA, UNESCO, UNHCR, FAO, ILO, WHO, WFP, World Bank with UNAIDS as the secretariat

[§] Joint UN Programme on HIV and AIDS (2006-2011) p.22

Non-Governmental and Community Based Organizations (NGOs & CBOs) and networks

Numerous private and voluntary organisations implement HIV/AIDS activities funded by donors. There are currently almost 200 NGOs and CBOs working in the area of HIV/AIDS. Several networking mechanisms have been established to co-ordinate their work. *NANGAN* (*National NGO Network Group against AIDS Nepal)* was established in 1995 and is now a consortium of 174 NGOs in Nepal, working to coordinate and share information, education, and communication materials, experiences, and lessons learned. *Nepal HIV/AIDS Alliance*, a consortium of 42 organisations is advocating for a multisectoral response at district and national level and for mainstreaming HIV/AIDS in various Ministries and in development projects. The network is currently awaiting registration with the International HIV/AIDS Alliance. The *National Association of PLHA in Nepal (NAP+N)* was registered in 2003. The network co-ordinates 54 PLHA organisations in 23 districts and grassroots organisation to facilitate access to services for PLHA and provides support to PLHA and their families. Moreover 5,000 PLHA are registered as network members. They are affiliated to the Asia Pacific and Global network of positive people.

The network organization Recovering Nepal focuses its support to organizations working with Drug Users including injecting drug users. They provide information on funding sources and technical assistance and support organisations to draw up their management arrangements and develop proposals for funding. The network is affiliated with the International Network of Drug Users and the Asia Harm Reduction Network. The National Harm Reduction Network is co-ordinating the work of 8 NGOs implementing harm reduction interventions. Sex Workers' Association of Nepal (SWAN) is a network for NGOs/CBOs addressing needs of FSW. Currently no national network for the various organisations working on MSM exists. The National Network against Girls' Trafficking, a coalition of approximately 40 NGOs initially established to tackle the problem of girl trafficking, has also begun to address the issue of HIV.

All the community based networks have received technical support from EDPs, INGOs and international networks to build their capacity. They have developed standard operating guidelines and are passing on their skills to the new office bearers. In the absence of a broad based capacity building plan, the support provided by the networks, especially the network of positive people and drug users has been the only source of technical support to the new organisations commencing work in their area. The networks, if supported with financial and technical resources, have the potential to deliver a large portion of the capacity building needs of Nepali civil society organizations.

National Monitoring & Evaluation Systems

The existing HIV & AIDS sentinel surveillance was initiated in 1991. However a systematic and continuous surveillance system that provides prevalence data in general and at risk population is yet to be established. The HSS intended to cover five sub-populations (female sex workers, patients with sexually transmitted infections, injecting drug users, antenatal care attendees, and tuberculosis patients) and seven surveillance sites (Kathmandu, Pokhara, Nepalgunj, Mahendranagar, Nuwakot, Daran and Sindupalchowk). However, due to different protocols being

followed in different sites, site location and sample size changes, and national protocols being altered, data are incomparable in time and epidemiological trends can not be evaluated.

The surveillance plan developed by the NCASC now covers the most at risk populations viz. FSWs, clients of FSWs, including labour migrants to Indian cities, IDUs and MSMs. FHI had conducted periodic behaviour surveillance surveys among MARPs; sero-surveys have also been conducted. Information for triangulation is also available from PMTCT sites, blood banks and TB clinics. The NCASC, with support from USAID/WHO, is currently reviewing its entire surveillance strategy with the aim of strengthening the second generation surveillance system in Nepal.

Intensive work has been undertaken to develop one national M&E strategy, which was completed and published in December 2006. This is an ambitious programme, which could take some years to stabilise. The first training of trainers on the national HIV/AIDS M&E system has been conducted. Subsequently a series of 5 trainings are planned for partners in Kathmandu and several regions. The NCASC believes that they will get sanction for additional posts needed at district, regional and headquarters. The capacity building load of reporting, analysing and disseminating the information is likely to be immense and will need additional investments by EDPs in future. Rather than develop a separate M&E system for health related interventions it will be helpful to pull the data out of the Health Management Information System so that AIDS related services are also monitored by the health system.

1.4 National response to HIV/AIDS

The Nepal MDG Progress Report, 2005 indicates that without intensified and accelerated HIV prevention efforts, Nepal will not achieve its MDG of halting and reversing the spread of HIV by 2015. However, concerted efforts of EDP, civil society and government have resulted in a rapid expansion of service provision over the past 2 years and an increasing proportion of most at risk population groups are being reached with prevention services, although there is no time for complacency.

As shown in Table 3 the coverage of outreach work among most at risk groups has been good in Kathmandu valley though not in the western districts and not among MSM. There are also issues of quality and low achievement of some desired outcomes.

The draft National HIV/AIDS Strategic Plan (2006-11) has comprehensive strategies as part of the national response. Since all strategies appear to be accorded equal weight in the draft document and since there could be a resource crunch, the NCASC may have to, in consultation with major stakeholders, decide on priorities for implementation so that interventions urgently needed in the current epidemiological stage, (e.g. prevention interventions among MARPs, treatment of STIs, VCT, OI management and ART) are funded before others.

Health sector response

The health sector response aims at improving availability and access to VCT, STI services and treatment and care services throughout the country. This is an essential component of national response in a concentrated epidemic as it provides the needed bio medical prevention, diagnostic and treatment services to MARPs and general population who may need them.

VCT: The availability of VCT services has increased from 9 service points in 2004 to 65 service points in 2006, mainly provided through private/NGO facilities. The GON is committed to further improve access by providing at least 2 VCT service points in each district by 2011. VCT guidelines, modelled on the WHO module, exist but the quality of service is not assured. While a marked increase in the numbers of people seeking testing has been observed (no data available for the nation; 1,658 counselled and tested in 8 VCT centres established with GFATM support), in general available sites are under utilised. Demand generation with stress on awareness raising on the importance of knowing your status and normalising HIV testing is needed. Systems are also needed to refer the VCT attendees to other service providers such as STI treatment, PMTCT, OI management, ART and support groups. The majority of people tested are people seeking work in the Middle East Employers in the Middle East require all workers to have a mandatory HIV test (on average 500/day).

ART treatment: An antiretroviral treatment protocol was endorsed by the Ministry of Health and Population. Anti-retroviral treatment (ART) was introduced in the public sector in 2005 and has been scaled up to 7 sites in 2006 (another 7 sites are expected in 2007), while treatment for Opportunistic Infections are provided at 10 sites. As of October 2006 473 patients are on ART. This is 5% of those in need of treatment (UNAIDS fact Sheet, Nov'06). Most of the patients access treatment at government sources. Only two private pharmacies sell ARV drugs. Other than MAITI Nepal, who obtains drugs with private/NGO funding, most of the NGOs who manage community based ART access treatment from government hospitals[**]. Paediatric AIDS Care and treatment is currently not available, but with support of UNICEF one site will be opened in 2007 in Kathmandu. NK+ and NAP+N are actively involved in treatment literacy training amongst PLHA.

PMTCT services: UNICEF is supporting expansion of PMTCT services and a further expansion from 7 to 9 sites is planned for 2007. However, ANC coverage is still low at 44% with large disparities between rural and urban women (85% vs. 38%) and only 19% of babies are delivered by a trained health professional and only 14% are delivered at a health facility (DHS 2006 preliminary findings,), indicating the significant challenge at hand to expand access to PMTCT services. Currently 7 health facilities provide PMTCT services, 23 care providers are trained in PMTCT service delivery and as of Dec' 06 18 women had received a complete course of antiretroviral prophylaxis (GFATM data Dec'06).

STI services: Government guidelines for syndromic management of STI have been developed and disseminated. There has been a marked expansion of STI services. In government STI treatment is part of the health system. The EDPs also treat STIs as part of the reproductive and sexual health services. E.g.: the Family Planning

[**] Personal communication, FHI Nepal

Association and Marie Stopes Clinics provide treatment for STIs. Many also seek treatment from private practitioners and pharmacists. Therefore reliable information of provision an access to STI provision is not readily available.

Nepal had benefited from an EU supported project (1994-2001) that had developed STI treatment guidelines, training manuals and logistics arrangements. A recent UNAIDS/WHO review showed that the STI treatment systems need revamping. NCASC is working on an action plan for training all the health workers and pharmacists on syndromic management.

Targeted prevention interventions: the HIV/AIDS strategy identifies the need for the provision of comprehensive packages to vulnerable and at risk population groups, including peer-led information, education and communication, STI services or referral, VCT service or referral, condom distribution and community sensitisation.

Programmes to reduce the continued spread among Injecting Drug Users: In most Asian countries, IDUs are the first community to be affected by HIV. Nepal was the first developing country to establish a harm reduction program with needle exchange for IDUs. However, due to the program's limited coverage, the impact on HIV transmission has been limited. HIV prevalence among Nepal's estimated 19,850 IDUs varies by location. (Table 2) Currently the NCASC estimates that only 8.6% of IDUs are reached by prevention interventions while FHI estimates the coverage to be 15%. The target for 2011 is 80% and the NCASC is working towards a comprehensive programme for IDUs – from demand to harm reduction to reintegration – in collaboration with ministries of Health and Population, Home Affairs and Labour.

Programmes to reach Female Sex Workers and reduce trafficking of women to India: The number of FSWs in Nepal is estimated in the range of 25,400 and 34,100 concentrated in the urban areas of Kathmandu and Pokhara and the East-West highway. USAID and its technical partners-FHI, Constella and PSI- invested almost half of their programmatic funding in this area. They estimate that they have reached more than 85% in Eastern Terai and Kathmandu, 70% in Western Terai and 57% in Pokhara while limited programmes reach FSWs in other districts. Driven by poverty a large number of girls are trafficked into India for sex work. The National Network against Girls' Trafficking, a coalition of approximately 40 NGOs initially established to tackle the problem of girl trafficking, has begun to address the issue of HIV.

Programmes to reach MSM: The Blue Diamond Society, a Non-governmental Organization (NGO) founded in 2001, is addressing the needs of Nepal's sexual minorities. The knowledge of safe sex and condom use is low in this community. Furthermore, many men who have sex with men are also married, which puts their spouses at risk of becoming infected with HIV. Blue Diamond provides community-based sexual health, HIV/AIDS, and advocacy services for local networks of sexual minorities. Their work has been expanded to 15 urban centres, covering an estimated 22 % of the MSM population. However, there remain many districts with no interventions among MSM population

Programmes to reach migrant populations: Mobile populations, especially people who migrate to Indian cities for work, are highly vulnerable to HIV infection. Without

social support systems and access to prevention services they adopt unsafe behaviours that place them at great risk of HIV infection. The measures currently undertaken include community orientation and sensitisation, district information packages and destination packages. About 28% of the migrants have been reached. But since new age cohorts join the migrant population continuously these interventions will need to be maintained. They cannot be sustained without support from agencies in destination areas.

In addition to the most at risk populations the national programme also works with other groups that are vulnerable to HIV. Young persons are provided HIV related information through life skills based education in schools, peer education and Youth Friendly Information service centres managed by UNFPA, UNICEF, Nepal Red Cross Society and FPAN and some NGOs. BSS conducted with sex workers have shown that 38% of their clients are from the uniformed services. To address the risk faced by uniformed services a 6 year HIV/AIDS programme that focuses on awareness and peer educators has been launched.

A summary appraisal of the national response

Political support: There has been an acknowledgment of the seriousness of HIV/AIDS as a threat. Unlike many other developing countries there has been no denial of the drivers of the epidemic even though the risk behaviours are not socially sanctioned and some of them are illegal. While legal impediments remain, hampering efforts to address vulnerabilities of the most at risk populations, national authorities have been supportive of the work of EDPs and civil society among the at risk populations. While national level monitoring bodies have been set up they have not been functional. This is not surprising given the political turmoil and conflict the nation has gone through. Unlike in many countries, which have faced comparable internal conflicts, the prevention programmes continued and the country did not witness a spurt in prevalence. When elected representatives take over governance of the country civil society groups are hopeful of a regime that is more responsive to the needs of the infected and affected people. It may also see the mainstreaming of HIV in plans of different ministries with budgets earmarked for HIV related activities.

Institutional arrangements: Following the practice in the initial days of response to AIDS, a lead agency for AIDS programming (NCASC) was set up in the Ministry of Health. But while other nations, appreciating the need for a flexible and multisectoral response to AIDS epidemic, invested the lead agency with varying degrees of autonomy, Nepal has only now begun to examine different management options for more autonomy and more linkages to non-health sector ministries. District level structures that can build on the strength of the decentralised governance system of Nepal have been set up. The budget lines too follow the health department structures and are a constraint to the NCASC accepting and managing additional funds needed for the national response. The institutional arrangements do not include a nationally led arrangement to coordinate the activities of different EDPs and other sector ministries.

Planning and implementation: Lack of a system to collect data that can assist planning is a major lacuna in the national response. This includes a systematic and continuous surveillance system and data on activities by various partners in the

AIDS response. The planning process has sought to utilise the national expertise through a participative planning process but structures and systems formalising participation does not exist.

NCASC recognises the need for standard guidelines for different components of the national response. Some have been developed and others are in the pipeline. If they are developed in a consultative manner it will help harvest the national expertise that exists and facilitate ownership and adherence by the implementing partners. The decentralised government systems, which have considerable expertise in developing and managing programmes, have not been associated in the planning and implementation processes.

Monitoring and evaluation: Most of the implementing partners have programme-based monitoring structures. But their outputs are not consolidated to yield data on the national response. To rectify this NCASC has developed a National M&E framework. When operational this will provide data on inputs and outputs of the national programme. Impact is being measured today by different agencies. The M&E system also needs a mechanism to analyse the data and to provide feedback to reporting partners and to decision makers at different levels.

Coalition building: Nepal has civil society organisations and community based networks with high levels of commitment and capacity. All partners recognise this and have invited them to participate in decision making at different levels. But this is often ad-hoc. The national response would gain by formalising these partnerships. The role of non-health sectors in the response to HIV/AIDS was recognised when other ministries were made part of the NACC and CCM. However, a lack of national ownership and leadership has led to the non health ministries adopting a peripheral role in the AIDS response.

1.5 Challenges and limitations of the National Response

Need for data to guide the response

Since HIV/AIDS epidemic in Nepal remains concentrated in specific sub populations most at risk of infection, the response needs to focus on them. Data on them are patchy, but coverage most likely inadequate, especially in the western and eastern districts. The first step of an adequate response is to generate baseline data on the location and numbers of the MARPs[††]. This data must be periodically updated to assess whether MARPS have moved to other locations, whether there has been a change in their numbers and to assess the extent to which MARPS respond to prevention interventions. Community based organisations, with technical and institutional support, are best placed to generate this data. NGOs and CBOs have to be engaged in such a way as to reach an effective coverage of at least 80% of the MARPs.

[††] The size of the one of the MARPs, MSM, is currently estimated at 10%. However, recent size estimates have brought our knowledge of the prevalence of (regular experience of, as opposed to life-time experience of) same-sex behavior in Nepal more in line with the situation in other parts of the region (i.e. around 2.5 – 3% of the male population) – this should result in a better allocation of funds across MARPS in the next phase.

The Government of Nepal has identified the need to put in place second generation surveillance and adequate national HIV monitoring and evaluation systems. Adequate and relevant data is essential for advocacy with policy makers for enhanced support and for use by programme managers to plan response appropriate to a dynamic epidemic. The national surveillance and M&E system should include adequate surveillance of risky behaviours and HIV prevalence among MARPs, surveillance of STIs and other biological markers of risk, surveillance and tracking of HIV prevalence in blood bank donors, TB patients and clients of VCT centres as well as AIDS cases reported and ART and OI treatment provided (inc. therapy compliance) desegregated by sex and age.

Need for quality assurance and confidentiality

Quality assurance and confidentiality of services provided is very important in AIDS programming. Adequate capacity building and on-the-job training programmes, utilisation of simple user friendly guidelines/standard operating procedures for comprehensive service delivery and adequate monitoring and supervision mechanisms, should be developed. Currently there are capacity issues constraining internal and external quality assurance mechanisms. But investing in quality assurance mechanisms is vital for effectiveness and credibility of the programmes.

Need for stronger linkages with existing services and networks

Stronger linkages are needed between the TB programme, which has been very effective in Nepal, and VCT services. The government should consider providing VCT services as an opt-out service to patients on TB treatment as a recent HIV prevalence survey revealed a HIV prevalence amongst TB patients of 2.4% (National HIV/AIDS Estimates, NCASC 2005). Similarly, an opt-out approach should be considered for women coming for ANC in locations where PMTCT services are within easy reach. Stronger linkages of VCT services with STI diagnosis and treatment services should be explored. Outreach workers for AIDS prevention should also contribute to demand generation for sexual and reproductive health services, especially for adolescents as positive spin offs for both programmes could be large.

Need for better utilisation of NGO networks

NGO networks had emerged in Nepal early in the national response, growing in the space left by a weak government response. They have benefited from capacity building activities by INGOs and EDPs. Many of the committed and competent people stayed on in the sector, supporting grass root level NGOs in management and technical issues. This role can be formalised and expanded if the networks are provided technical and financial support to help other organisations.

Need for better co-ordination at national and district level

Due to the civil and political turmoil in Nepal, HIV/AIDS as a development issue has not received the importance it might otherwise have. The Government has not prioritised the issue of HIV/AIDS and mechanisms set up to co-ordinate and guide the national HIV/AIDS programme are not functioning. Ad hoc technical working

groups and stakeholders meetings, chaired by the government have facilitated joined decision making on plans and programmes and identified priorities. Many EDPs have their own implementing arrangements and work directly with CSOs. This has resulted in the country making significant progress in reaching at risk population groups. However the lack of engagement by government takes away national ownership of the programme and the establishment of sustainable mechanisms for co-ordination and resource allocation and mobilisation based on identified gaps and under-served areas, avoiding duplication and capitalising on synergies. This creates major gaps in information on national response and prevents optimal use of resources.

The Government has to provide leadership to the programme. The new National Strategic Framework 2006-2011 is still only a draft document, and the 2-year national implementation plan for 2006-8 has not yet been finalized. UN and other development partners should step up evidence based advocacy so that government has a realistic assessment of the situation and is willing to lead the process.

With the maturing of the epidemic impact mitigation is likely to emerge as a major challenge to Nepal. This can be addressed only in collaboration with poverty alleviation, micro – credit and other development programmes. The AIDS programme need to establish links with initiatives such as Poverty Alleviation Fund which work on poverty issues and other agencies which work on nutrition, child protection and income generation/micro credit.

Need for reorganisation of the National Centre for AIDS and STI Control

The status of the NCASC as a wing of the health department, its inability to hire persons with skills appropriate to its tasks, its problems to manage funds allocated by EDPs, its difficulty in contracting-out to NGOs/CBOs and the lack of flexibility and authority to directors has been debated for some time in Nepal. The EDPs have been urging the Government to establish a 'semi-autonomous body' to facilitate a stronger non-health sector response to HIV/AIDS, modelled on similar structures created in Cambodia and other countries. This does not appear to be supported by health department officials who insist on seeing HIV/AIDS as a predominantly health issue. They are, however, open to amending existing structures for greater flexibility to retain competent staff and delegation of authority from above, which will help the institution take decisions more promptly. There is an opportunity for substantial changes to existing structures and NCASC has plans of re-examining the options paper, studying structures in neighbouring countries and making recommendations for a revamped structure to be constituted by a cabinet order or an Act of Parliament.

2. REVIEW OF THE UNDP/DFID SUPPORTED PROGRAM

2.1 History and rationale

In 2002, the Nepal Country Coordinating Mechanism (CCM) submitted a proposal for HIV/AIDS work to The Global Fund for AIDS, Tuberculosis and Malaria (GFATM) Round 2, which was subsequently approved for a total of $11,173,542. The work plan under Phase 1 was approved for $4,365,996. During the same round, the Nepal CCM also submitted a proposal for a malaria program. The Principal Recipient (PR), the Ministry of Health and Population (MoHP), Government of Nepal (GON), signed the grant agreements on August 13, 2003. However, there were significant delays in start-up and implementation of both programs and in the achievement of targets.

With respect to the HIV/AIDS grant, after 10 months of implementation by government work had progressed toward only one out of the 18 results, namely "number of government staff who received training." All of the other 17 results, which have service-related output and outcome indicators, had zero (0) targets achieved. The GON subsequently requested the United Nations System in Nepal through the United Nations Development Programme (UNDP) to support the implementation of the HIV/AIDS grant by managing some of the GFATM-funded activities and to function as the Management Support Agency (MSA). The UNDP/MSA agreement was signed with the GFATM and GON on February 22, 2005. UNDP subsequently established a Programme Management Unit (July 2005) and commenced with programme execution/implementation in August 2005. The involvement of UNDP as the MSA has resulted in 80% and above achievement of all of the targets under the responsibility of the UNDP/MSA, which amounts to a total of nine of the 18 results. The GON, through the National Centre for AIDS and STD Control (NCASC), retained responsibility and funding for the remaining portion of the program and has achieved 80% and above on three of nine indicators under their purview.

In the Phase 2 submission, the CCM has requested that the UNDP/MSA continue for two more years until the end of Phase 2 in order to facilitate and enable transition of all implementation activities to a local institution.[‡‡]. The first phase of the GFATM programme ended on the 30th of September 2006. A performance appraisal of the programme by GFATM recommended UNDP to change its role from management agency to principal recipient of the fund, which is effective as of 1 January 2007.

The DFID supported programme

DFID approved £15 million over 5 years on October 24th 2004, to support the GON's National HIV/AIDS Strategy (2002 – 2006) and Operational Plan (2003 – 2007). The implementation modality is governed by a tripartite arrangement between DFID, UNDP Management Support Unit (MSA) and the GON. Under the agreement funds

[‡‡] Wilma Gormley et al, consultants, entitled "Global Fund Program in Nepal: Technical Assistance Report", November 2006

were to flow to the UNDP's MSA and the MOH's National Centre for AIDS and STD control (NCASC)

In September 2005, DFID contributed 4.4 million USD under the umbrella of the MSA/GFATM agreement. In June 2006, an expanded agreement between UNDP and DFID worth 6.9 million for 2006-8 superseded the agreement reached in September 2005.

2.2 Institutional arrangements and processes

Processes for selection of implementing partners

Two implementation modalities were agreed upon for the DFID funded programme: the first was 'RFP' (Request for Proposals) for more established NGOs working on migration issues, and the second process combined Fast Track and Challenge Funds, aiming to support interventions for high risk populations by less established NGOs and community groups based on a criteria established by a stakeholder group and Challenge Fund managed by NAP+N who provided small grants to community based organisations. A meeting of stakeholders decided which of the services lines should go into the RFP, Fast track and challenge fund streams. Both implementation modalities were overseen by a Technical Review Panel (TRP). For the RFP this panel consisted of the NCASC, UN representatives and external consultants and for the Fast Track funds the UN Focal Points for HIV/AIDS.

The RFP funds were announced in newspaper advertisements between 20-22 November 2005, including the areas of work requested and criteria for eligibility, and a deadline for proposal submission on 9 December 2005.

The areas of work were:

RFP–21	Establishment of info centres for mobile populations in 9 districts
RFP–22	Community orientation and sensitization for HIV prevention, care and support in 9 districts
RFP–23	Use of traditional media for awareness raising among mobile populations in 9 districts
RFP–24	Advocacy for strengthening prevention services and providing supportive environment to access HIV/AIDS services in 9 districts

Later two more RFPs were added with a deadline of 9 March 2006:

RFP–25	Comprehensive package for mobile populations and families
RFP–26	Behavioural study of prison population

Criteria for organizations to apply were that they had to be NGOs registered with the appropriate authority for a minimum of three years, with a valid certificate of registration, possess a valid licence issued by the Chief District Officer of the district for which they have submitted proposal and have a proven track record over the last three years of working in programmes in the area of HIV/AIDS. Twenty one NGOs applied; of those 17 passed the initial screening of the advertised criteria. Then a technical review occurred, an evaluation scoring sheet was developed, and NGOs

obtaining a score of at least 70% were included in the next step, a screening of finances / proposed budget. Here, a score was given as follows:

$$\frac{\text{Lowest bid offered}}{\text{Bid of the particular organization}} \times 300 = \text{SCORE}$$

At about the same time, an advertisement for Fast Track (including Challenge funds) was placed in newspapers on 1 December 2005. The advertisement included the areas of work requested, eligibility criteria and maximum funding available per organization / network for each service line.

The areas of work were:

1. Comprehensive package for male sex workers in Kathmandu
2. Comprehensive package for IDU (harm reduction) in 12 districts
3. Drug treatment / rehabilitation for IDU in major cities
4. Comprehensive package for MSM in Kathmandu and 16 cities
5. Comprehensive package for PLHA in urban areas

There was no deadline for applications. Instead, funds were capped for different thematic areas of work, later subdivided according to region. Proposals were accepted on a first come, first serve basis till the entire allocation in each service line ran out. A Q&A session for NGOs was held on 7 December 2005 and proposals were accepted starting on 12 December. A log was maintained with proposals, and 153 proposals were received of which 66 qualified for the criteria set in the guidelines for application. For these 66, an evaluation scoring sheet was developed, and NGOs obtaining a score of at least 60% were included in the next step. Fifty four NGOs passed the technical screening process, and in the end 47 received funds for the first period (December 2005 – June 2006, with no-cost extensions granted till 31 December 2006). In July an assessment of all projects was done (the so-called ODC assessment). Six NGOs did not make the grade and were consequently dropped. Then NGOs were invited to bid for the second round (August 2006-June 2007). A similar process was followed, where the assessment of the evaluators weighed for half and the submitted proposal for the other half in scoring. Winning NGOs signed a long-term agreement (for 2 years – August 2006–December 2008) with UNDP and were given funds for the first year, until October 2007.

All the components of programme implementation except procurement were to be managed by the NGOs. Cost of materials was to be deducted from the grant allotment and different commodities are to be procured and supplied by different agencies. Condoms are procured by UNFPA and are obtained from the logistics chain managed for the GON by USAID. Drugs are procured through a Long Term Agreement with UNICEF. For all the other items the procurement wing of UNDP obtains the items following their global procurement guidelines.

2.3 Preliminary outputs and results

Under the GFATM and DFID funded programme HIV/AIDS prevention and care activities were implemented through 119 projects delivered by 77 NGOs in 27

districts in 2006. The activities implemented range from information and awareness; peer education; Voluntary Counselling and Testing and Sexually Transmitted Infection services; harm reduction; rehabilitation; and care and support to people living with HIV/AIDS and safe blood supply. The services are primarily provided to mobile populations and their families; young people; injecting drug users; people living with HIV/AIDS, uniformed personnel, men having sex with men and male sex workers to reduce their risk of HIV/AIDS infection.

The recent 'Global Fund in Nepal: Technical Assessment Report" (November 2006), states that of the four Principal Recipients assessed in their consultancy, "(…) UNDP/MSA (…) ha[s] performed very well and [is] meeting their GFATM targets. It continues that [UNDP/MSA] 'has talented and experienced managers leading their programs. Work cultures embrace productivity and efficiency; staff members are goal and deadline driven. UNDP […] [has] skilled motivated Nepali staff members who find conquering the challenges of managing a GFATM performance-based grant rewarding, and they have mature, reliable systems to support their work.'

Nevertheless this positive assessment by a team of outside consultants, UNDP is aware that there are still gaps, both in the management of the grant, and especially in the provision of technical assistance (other than (financial) management assistance) to implementing NGOs.

At the national level, UNDP has contributed to national efforts to strengthen M&E and logistic management of HIV related supplies (including syringes, condoms and ARV medicines).

Based on the funding norms adopted by the national action plan (2006-2008), UNDP has developed a funding criteria. UNDP has also developed an M&E framework to facilitate programme monitoring, although concerns were expressed by programme partners that the reporting requirements and reporting forms were not developed in a participatory way utilising the expertise from NGOs/CBOs (see section 2.4).
Since indicators for measuring progress were not standardised at the beginning of the programme, the indicators used are not yet comparable across projects. Moreover, the difficulties experienced with need based planning at programme inception is most likely the explanation of the uneven achievement of targets as revealed in table 5.

As can be derived from Table 5, the level of progress varies widely between different activities in the same service line, indicating that NGOs and CBOs are responding to emerging needs rather than work according to a prior plan. It will be important that NGOs be requested to update targets for the 2007/2008 project year, based on field knowledge gained from two years of implementation (2005-2007) so that future programmes will address actual needs and organisations get credit for what they do. More rigorous definition of some of the indicators (e.g.: Does peer education mean mere contact or a predetermined level of health education?) will also improve programme monitoring.

Table 5: Achievements of the DFID/UNDP HIV/AIDS programme for MSM and IDUs – June 2006

Service Line	Activities	Achievement against target set in project proposal (%)
Comprehensive package for MSW/MSM	Community sensitization	52.67
	Peer education	65.63
	Condom distribution/social marketing	40.29
	Procurement of condoms	10.92
	Establishment of STI/VCT service or referral links	32.10
Comprehensive package for IDU	Primary Healthcare Services	75.18
	IEC/BCC-production, printing and distribution	55.00
	Community sensitization	63.45
	Peer education	240.00
	Condom distribution	120.08
	Establishment of STI/VCT service or referral links	13.08
	Counselling and psychosocial support	75.10
Drug Treatment	Rehabilitation programme	127.50
	Reintegration programmes	50.30
	Establish linkage to ART programme	13.50

(Source : Calculated from UNDP progress reports)

Table 6. Expenditure of the DFID/UNDP HIV/AIDS programme as of October 06 (USD)

Sl.no	Service lines	Budget	Expenditure	% of Exp/ budget	As % of total
1	Comprehensive package for MSM/ MSW	592,837	333,428	56%	12.69
2	Comprehensive package for IDU	226,051	464,781	205.61	17.69
3	Drug treatment	787,417	335,408	42.60	12.77
Total 2 &3 DU/IDU		1,013,468	800,189	79%	
4	Comprehensive package for mobile populations	1,479,755	901,277	61%	34.30
5	Comprehensive package for PLHA	56,296	169,202	300.56	6.44
6	Adults and paediatric care	750,000	99,000	13.20	3.77
Total 5 & 6: Care/support PLHA		806,296	268.202	33%	
7	Safe Blood Supply	75,000	74,617	99.49	2.84
8	M&E, Capacity building, Research	150,000	41,981	27.99	1.60
9	UNDP costs	329,388	207,816	63.09	7.91
	Total	4,446,744	2,627,511	59.09	100.00

2.4 Findings, concerns and challenges observed/identified by the consultant team

Findings of the review of the DFID/UNDP HIV/AIDS programme can be classified into two sub-categories: i) those that flowed from the design of the programme and ii) those attributable to the manner of implementation by UNDP.

Findings related to the design of the DFID/UNDP HIV/AIDS programme

Priorities for the DFID/GFATM supported National Program were based on the broad guidance provided by the National Strategic Framework 2002-2006 and the related Action Plan for 2005/6. A detailed situation response analysis and detailed information on estimated most-at-risk target audience in each district was not available. Only recently UNAIDS completed a mapping of ongoing interventions per development region. A need-based allocation of funds per district was therefore not possible and was consequently not used as the basis for approval of project proposals submitted. Primary stakeholders of the programme, the Most at risk populations, have been the focus of prevention interventions for more than a decade and information on the essential and comprehensive packages of services needed for effective prevention, care and support services, including guidelines for budgeting and costing are readily available. However, clear guidelines and non-negotiable minimum standards for service provision were not set at the time of proposal review. Consequently the basis of the process followed by the Technical Review Panel to cut elements of comprehensive packages proposed are not obvious. Moreover, no recommendations were provided to further improve proposals, which did not include comprehensive packages.

A variety of training and IEC materials are used in the field. While some materials were supplied by UNDP, materials were also obtained from a variety of other sources. Some NGOs have prepared their own IEC and training materials. No system is currently in place to assess the quality of materials used and/or the impact of the trainings and awareness activities conducted.

Findings related to the implementation of HIV/AIDS programme by UNDP

The entire process has been by and large transparent: the announcements, criteria, meeting minutes, scoring sheets for each organization and minutes of the final decisions have been documented. The grant processing modalities followed (first come first served rather matching funding to needs, working with experienced NGOs rather than developing capacities of local NGOs in locations where projects are sanctioned) ensured fast funding and grounding of interventions This came at a time when funding was becoming scarce for existing NGOs and limited funding was available for work at grassroots level. But it also led to many established, Kathmandu based NGOs accessing funding for working in far–away districts with limited opportunity for local NGOs and grassroots organisations to apply for funding. The lack of provision in the design for capacity building also contributed to this phenomenon and impacted on the quality of many interventions and possibly its sustainability

The UNDP team has delivered substantially on the outputs they were charged to deliver. The engagement of project NGOs was done in a transparent and speedy manner. Partly due to the capacity of the NGOs who were contracted, they have been able to engage personnel and get the projects grounded fast. The coverage of MARPs discussed earlier was achieved by this speedy scale up. The coverage reached by outreach workers shows that community based activities have been pursued vigorously. Achievements of the projects are substantial, although due to a slow start and limited duration of the programme not all targets were achieved. (Table 5 and 6).

The NGOs managed to address some of the design flaws in the DFID/UNDP HIV/AIDS programme. District based offices of implementing agencies received management and technical support from their head offices including on-the-job training/guidance during field visits. The CBOs that were part of networks were also assisted by these networks.

While in April 2006 implementation was seriously hampered due to the political turmoil, NGOs reported that the current political situation did not influence/affect programme implementation.

UNDP is currently developing minimum standards for service provision. NGOs acknowledge the need for clear guidelines and operating procedures. Such standards and protocols will also facilitate standardisation of reporting mechanisms and assist field officers in conducting facilitative supervision. Partner organisations indicated that they would appreciate a more active involvement in the development of M&E forms and other standards to ensure that these will be appropriate for field level use. Various NGOs indicated that they felt that their expertise was not utilised during this process, but that instead UNDP developed the forms and expected NGOs to utilise them in a top-down manner.

Partner organisations appreciated the supervision provided by the UNDP, although most projects had only been visited once or twice. NGOs welcomed more frequent visits and on-the-job guidance/training. They also appreciated that UNDP staff were overburdened with work, having to provide support to over 77 organisations, and welcomed the recruitment of additional staff (i.e. a finance assistant and four field-based project officers).

Partner organisations appreciated the external review conducted by ODC. However, the final report has not been disseminated to the NGOs.

There have been complaints from implementing partners regarding contract and finance management practices by PMU. When contracts were renewed after extension of the initial period they were signed long after the official starting date of the project. NGOs with other sources of funding managed to juggle their resources until the UNDP administered funds arrived – however, NGOs that were solely dependent on the UNDP administered funds suffered delays in implementation and some lost staff due to the late payment of salaries. Financial arrangements at UNDP may lead to delays in fund transfers. For a while there was only one person responsible for dealing with financial issues of 77 NGOs.

Many NGOs expressed concern that under the 2006/2007 contract agreement they were paid only 3 months of programming money in advance and were expected to submit quarterly financial reports and advance requests, which would take at least 1 month to process at UNDP. During this month the projects might not have sufficient funds to continue operations. This could affect provision of services with serious consequences as in substitution therapy and needle exchange programmes.

As was mentioned above, part from some technical support on finance and admin related issues, no significant technical support related to the contents of interventions was provided to implementing partners. This has sometimes led to duplication (especially in the development of training and IEC materials) and possibly to a lower quality of intervention for several key groups, including MSM. For example:

- The NGO Blue Diamond Society in Bhairahawa –contrary to what the team expected based on project documents – focuses on transgender only (see below), rather than being inclusive to other, more hidden MSM. Out of 23 outreach workers and peer educators 20 were transgender and only 3 were *tar* (i.e. masculine identified MSM). This will leaves a large number of MSM, who do not want to be identified or contacted by transgender in fear of being exposed, without basic prevention services. Oddly, the counsellor at BDS servicing mainly transgender, was one of the few non-transgender staff.
- The BDS office that was visited, and apparently most other NGOs did not conduct a baseline assessment before the project started; this may have led to lower client satisfaction with the services provided than might otherwise have been the case.
- The training of most counsellors in counselling centres was not specific to the target audience. For example, a counsellor in one of the IDU projects visited had never received training in problems related to addiction, and how to provide counselling to addicts; some explicitly requested technical assistance.
- The NGO Naulo Ghumti Nepal, working on peer education / outreach and counselling for IDU in Butwal, developed its own peer education / outreach manual; this could have been done together with other NGOs working in this field of work, or existing materials from other districts might have been adapted / used in Butwal. The same was the case for IEC materials.
- The NGO NAMUNA, operating in a border area with India, reported that many IDU using the counselling centre and reached by outreach workers could not read Nepali – they said there was a need for IEC materials in Hindi as well.
- Several IDU related projects reported that there was a lack of aftercare for IDUs coming out of rehab; they mentioned that UNDP had cut that part of their proposed program out. They noted, rightfully, that the chance of relapse is much higher if there is no social and vocational rehabilitation support for ex-addicts after their release from rehab. They estimated a relapse of 50%. However, a female rehab centre in Kathmandu indicated a relapse of 90%
- Since NGOs were approved on a first come first served basis there were duplications in some areas whereas some MARPs were left out. For instance in Makawanpur there are three organisations that provide support to PLHA. The load is not adequate to for three such organisations. There are no MSM projects in this region.

Blue Diamond Society (BDS)

The award of funds to Blue Diamond Society for responses to MSM and MSW has generated disquiet among the fund managers and among other civil society organisations.

BDS submitted a technically sound proposal, but its budget demands were out of line with funding norms followed by other NGOs/CBOs. Large variance was seen with respect to percentage of total budget utilised for operational costs and staffing (UNDP informed the team that only 30% of the BDS budget was allocated for programme activities) and salary levels provided to outreach workers (BDS outreach workers receive twice as much salary as outreach workers in other NGOs).

BDS refused to compromise on the budget issues UNDP took up with them,. During this process BDS accused UNDP and NCASC staff of 'discrimination', when attempts were made to rationalise the budget. In the end UNDP felt forced to approve, with much delay, the BDS program.

The consultants in this team believe this was a mistake, and regret discrimination against other NGOs, who comply with certain standards for staff numbers, office size, management cost and salary levels that has been accepted as part of the financing norms for the national action plan (2006-2008).

The team visited BDS's branch office in Bhairahawa.. Between May – November 2006, 1136 MSM and 582 MSW were contacted by the project. This makes for an average of around 8 MSM per day. This is too little, considering the fact that BDS Bhairahawa employs 35 fulltime paid staff, including a full-time doctor and a full-time lab technician.

A review of the BDS program is planned for 2007. It will be important that the organization's operating standards are brought in line with those of other NGOs and that staffing needs are assessed against the numbers community members to be served. The current development of 'minimum standards' and standard guidelines by UNDP will help achieve this, assuming that sufficient time is allocated to allow careful review and adaptation of the draft by NGOs/CBOs involved in programme implementation.

NGOs indicated that they often refer clients to each other and to other service providers. The lack of coordination between donors, the Government and key NGO/CBO partners at the central is reflected (in varying degrees) at the district level. However, in Chitwan a very active District AIDS Coordination Committee and a completed 2006-8 District HIV Strategic Plan were found. In Rupandehi, the DPHO had requested the NGO Namuna to prepare an inventory of NGOs working on HIV/AIDS in the district aimed at improving referral linkages between the various organisations and the government institutions.

UNDP has adopted a standardised costing pattern similar to the one adopted by the NCASC. While some of the NGOs may have disagreements with the norms used they are willing to accept this if it weren't for allegations of favouritism shown to one

NGO. They have been sanctioned budgets wholly disproportionate to similar interventions elsewhere and at much higher rates than what was sanctioned to other NGOs. No basis could be found to justify the discrimination which has caused considerable disaffection among other NGOs.

UNDP is procuring IEC materials, condoms, lubricants, needles and syringes for the programme partners. Lubricants are not locally available and delivery of the required quantity has been seriously delayed. NGOs indicated that condoms could also be locally obtained and no shortage of condoms was reported. UNDP is providing needles and 2 ml syringes at the required quantity. However, NGOs indicated the need for 5 ml syringes. Due to government regulations the request for 5 ml syringes could not be honoured.

Some civil society partners pointed out that the goods procured by UNDP on their behalf (the cost of which is reduced from their grants) are delayed, are more expensive and inferior in quality to what they could have obtained from the market themselves.

3. RECOMMENDATIONS AND FUTURE SCENARIOS

The recommendations of the consultant team have been divided into three sections – recommendations for the national programme in general, recommendations for DFID, and recommendations for UNDP.

3.1 Recommendations for the National Programme in general

These recommendations are meant to address some of the structural and programmatic constraints to the national response that the appraisal team had noticed. They are addressed to all the major players who have influence over management of the national programme.

1. Government of Nepal, Development partners and civil society networks should work towards a more suitable national institutional mechanism to lead the national response: Since the nation is moving towards a representative democracy a window of opportunity to mainstream AIDS prevention and impact mitigation will be available. The recommendation to establish an autonomous or semi-autonomous body outside government appears to enjoy a degree of support among EDPs. Based on our experience of similar structures in other countries and our discussion with government officials we feel that such an arrangement may not be the best option for Nepal, especially at this point in time. In the short term we recommend that the NCASC should be strengthened and reconstituted to better administer the national response.

The precise nature of the reconstituted NCASC has to emerge out of a consultative process led by the national government. The only preconditions to be set for the consultations should be that the body be led by the national government; that there is representation from related ministries, civil society and EDPs; that the body has a board which has delegated powers of government to take decisions on funding, technical assistance and contracting of NGOs and has adequate technical capacity to lead the programme. As a first step the recommendations of the task force constituted to study the issue can be disseminated and discussed. Participants to the discussion can interact with AIDS programme managers in neighbouring countries which have functioning institutional mechanisms. The reconstituted body can be established either by a cabinet decision or an act of parliament. Structure like the NACC, which may prove superfluous, can be abolished. DFID and other EDPs could support the consultative process and continue to provide technical assistance to the reconstituted body to carry out its functions.

2. An institutional appraisal of NCASC should be conducted to determine the number and profile of the human resources needed. Staffing norms in the NCASC should follow the results of the appraisal. Rather than being automatically posted, NCASC should be recruited against clearly defined job descriptions, qualifications and experience. Where such staff are available in government they should be posted to the NCASC with additional payment as an incentive based on responsibilities and achievement of outputs. When they are recruited from open market they will need to be supported by EDPs. But irrespective of the mode of recruitment and affiliation the

board will enter into an MOU with them with performance based indicators which they have to deliver to retain their position.

Restructuring of National Institutional Mechanism – The way forward

AIDS prevention and control programme needs to have a stronger national government led implementation mechanism. This is a necessary condition for accessing more funds from donors like GFATM and the World Bank. DFID could invest in supporting the process as this could leverage more funds than direct support to programme. Recommended pathways are:

1. A participative assessment of the strengths and weaknesses of the current system including HR policies, decision making, financing and monitoring systems. The assessment team should have at least a senior health department official, a civil society representative and a technical expert.
2. Identification of remedial measures: This could include
    a. A review of literature on national AIDS control authorities in nations comparable to Nepal
    b. Site visits and discussions with some of the functional National AIDS Control authorities in the region e.g: Cambodia, India, Thailand
    c. A review of the recommendations of the institutional reform task-force set up by GON
3. A facilitated consensus workshop to generate agreement on a structure acceptable to Nepal.
    a. As a first step the workshop could lay down non- negotiable conditions: delegated powers to make decisions regarding funding, staffing, technical support and support to civil society organisations; national ownership; representation from major national stakeholders.
    b. Develop agreement based on recommendations emerging from step 2 above. The process should involve persons with sufficient rank and influence to ensure that the agreement is honoured and followed up
    c. Agree on next steps in drawing up rules, HR policies, operating procedures, technical assistance and capacity building plan and assigning responsibility for funding and executing the steps agreed upon
4. Building capacity of officers selected by the new structure. This should also include agreement to ensure their availability to the national entity at least for a minimum period (e.g: No poaching guarantee from EDPs)
5. Review of effectiveness of the new structure after a year of functioning

3. Greater coordination is needed between development partners working in the area of HIV. The expanded UN theme group and the informal meeting of development partners have not been able to achieve alignment of activities of different partners. The theme group should remain a UN body to coordinate the activities of the different cosponsors of UNAIDS. There should be a larger forum which brings together partners who bring funding to the national programme. Activities of the forum will involve sharing of information on activities, synergising of activities

between different partners (as a start, capacity building activities) and, as the partnership matures, joint planning and programming based on the national HIV/AIDS strategy and related operational plans. The secretariat can be housed in one of the agencies, with regular periodic meetings and reporting from different partners consolidated into a regular report for the government.

4. The current informal coordination forum should move to greater transparency. The stakeholders do not have access to information on funds, activities and programme performance of different partners. There should be an annual review of the national programme, which covers all the partners of the national response. The preparation of a consolidated report and an annual public presentation of findings will induce greater transparency into the functioning of development partners. It will be helpful to publish the annual review report online.

5. The national programme needs a more comprehensive M&E system including a second generation surveillance system. A beginning has been made by developing national guidelines. But high levels of investments will be needed in human resources, technical capacity building, infrastructure and follow up for a national M&E system which incorporates inputs from all partners to emerge. Tracking of the epidemic and its drivers in general population should be added to the surveillance system to make it more comprehensive.

6. Networks have the potential to play a greater role in HIV programming and the facilitation/provision of capacity building. Civil society partners who work in programmes funded by different agencies in a district or region should be supported to come together so as to understand the work of others. They should act as a pressure group on the DDC to activate the DACC. Similar associations at the national level (including NANGAN or National NGO Federation if they are suitable) should be represented on the decision making committees deciding on programming (e.g.: Coordination committees committee of the UNDP – MSA).

7. There is a need to institute internal and external quality control measures. Internal quality control will need national standard operating protocols, proper training of personnel and adequate supervision. External quality assurance mechanisms involve external audit of operating practices and sample check of results. NCASC has commenced developing standard operating protocols for some areas and is working on the others. But quality assurance systems will also need investments in infrastructure and training.

8. HIV/AIDS Programmes need to be integrated with other related programmes. While demanding that AIDS programming be mainstreamed in other programmes EDPs like UNDP and DFID which support other programmes such as safe motherhood and poverty alleviation have to ensure that the AIDS prevention and support programmes are integrated with them and that the support is bimodal. Moreover, VCCT services should be normalised and opt-out HIV testing for TB and STI patients and ANC clients considered where appropriate.

9. High vulnerability of migrants to HIV and STI infection while in India needs to be addressed with innovative strategies involving Nepali migrant associations and

existing prevention efforts going on in India. GON needs to work with National AIDS Control Organisation, India to achieve this.

10. UNDP and DFID with development partners could consider playing a stronger role in advocacy for HIV/AIDS – the following areas stand out:

a. Leadership – work with UNAIDS and other UN agencies to encourage national leaders and influencers to publicly speak about HIV/AIDS;
b. Institutional reform – work with the World Bank and others to persuade the Government to make the needed structural changes
c. Provision of ARV – work with WHO to ensure that access to antiretroviral treatment reaches the rural poor and work with other agencies such as Clinton foundation to obtain support for expansion of paediatric aids care
d. Legalize substitution treatment, increase syringe size for IDU
e. Repeal the law criminalizing homosexuality (Section 377)
f. Improve the legal situation of sex workers
g. Protect the rights of people with HIV/AIDS especially in the workplace
h. Map the existing provision of different services such as STI treatment, VCT, safe transfusion services, diagnostic facilities for PLHA including paediatric facilities and services for MARPs. A beginning has been made by UNAIDS.
i. Identify the gaps in infrastructure, human resources, and consumables and negotiate with government and development partners to fill these gaps. Obvious gaps are provision of CD4 tests and improving quality control and capacity building. This could be done by working with other agencies with expertise in the field. (e.g: Clinton Foundation for provision of CD4 tests and quality control of laboratory tests)

3.2 Recommendations for DFID

1. DFID should continue its ongoing support to the National HIV/AIDS Program executed by UNDP, provided a strong capacity building process can be integrated in the ongoing process. Despite certain shortcomings in the current arrangements, it is a viable option to channel funds for a nationwide HIV program in Nepal in the medium term (up to 2009).

2. DFID's strength lies in their ability to be flexible to accommodate programming to suit national situation and in bringing in substantial resources. DFID has adopted a hands-off approach after contracting UNDP. This should change. DFID should use its comparative advantage to support integration of HIV/AIDS programmes with existing health programmes and advocates that health sector investment programmes be tapped to ensure adequate infrastructure, human resources and consumables. Moreover, DFID should be actively engaged in strengthening donor-government co-ordination mechanisms in support of the national HIV/AIDS response.

This shift will involve greater hands-on policy level engagement by the DFID Nepal office. Shifting responsibility of the programme from an administrator to a sector specialist as has taken place late 2006 was therefore an appropriate decision.

3. The resource gap for the current work plan is 47%. Given the uncertainty that surrounds some of the key funding sources (GFATM, USAID) DFID needs to consider measures to improve financial resources to Nepal's national programme. DFID could invest in supporting preparation of funding proposals to the GFATM and the World Bank and help manage the grants when received, including meeting the conditions set by the donors. DFID may also consider allocating funds to meet the gap left after assistance from other donors has been accounted for.

4. DFID has promoted the growth of new initiatives, especially by community-based organisations in many countries. Due to the modalities of funding adopted the support has tilted the funding pattern in favour of established NGOs. This has led to gaps of programming in areas where the established players do not operate. For the remaining of the programme DFID should advocate for the identification of NGOs and/or support the growth of new community based organisations in locations where interventions have not happened.

5. DFID should engage with government to create greater ownership and capacity so that they can take over management of the programme in the next cycle. This needs to be carefully managed and gradually executed so that the response does not diminish. Final shape of the national institutional mechanism will emerge through a consultative process involving national stakeholders and should not be dictated by the preference of any EDP. DFID should support and advocate for developing such a mechanism at the national and district level.

6. Since capacity building was identified as a major gap in the current program, DFID should help ensure that this essential component becomes an integral part of the program. While some funds for capacity building have been identified in the current budget, DFID should ensure that sufficient budget will be allocated for capacity building events in the next phase of the programme.

7. DFID should ensure that lessons learnt from DFID supported programmes elsewhere are shared with appropriate stakeholders in Nepal. DFID should facilitate exchange visits within the region as appropriate. At the same time, DFID should ensure that lessons learnt from the programme are well documented and shared within DFID and with a wider audience as appropriate.

3.3 Recommendations for UNDP

1. In order to show commitment to its stated principle that UNDP aims to support the Nepali Government in implementing a National HIV/AIDS Programme, UNDP should formalise systems for information sharing and greater involvement of NCASC.

2. UNDP in consultation with DFID and programme partners should consider a modality to provide more and better technical support to the projects it supports.

Most of the current technical capacity has been built by INGOs working in the sector, often on an ad-hoc basis. UNDP should work with these INGOs and the existing NGO networks to develop a national capacity building plan. This should entail twinning of the Networks with international institutions or one or more international experts with a proven track record in capacity building in particular areas of work, for example, Asian Harm Reduction Network, WHO and UNODC for IDU / harm reduction, APN+ for PLHA related activities, EMPOWER, Oxfam or FHI for sex work related interventions, FHI, the Naz Foundation for the MSM/MSW TG related interventions, or the Migrant Network of Asia (MAP) or CARAM Asia for mobility-related issues. These organizations could work with the Networks, for mentoring and technical monitoring; through a Training of Trainers process so that a pool of National Expert Trainers are available in different areas of work[§§], to support a structured process of capacity building of local NGOs and CBOs in the districts. The capacity building activities should start with the development of user-friendly protocols, standard operating procedures and IEC materials. These should be available at all service sites and that staff/volunteers are trained in its use. The VSO programme, where volunteers are attached to civil society organisations, could be used to provide on site handholding, especially in the area of management support.

3. UNDP should act on the recommendations made in the November 2006 Technical Assistance report – i.e. put a system in place through which UNDP's own staff can learn about the latest technical developments in HIV/AIDS, as well as set up a system in which this information can be disseminated to implementing partner agencies. UNDP also needs to set up learning systems so that they can learn from experience gained by NGOs in the field. This could take the form of experience sharing meetings at district level where field functionaries share their learnings, which are documented and disseminated by UNDP.

4. Additional staff to help implementing partners with their financial management and reporting duties is needed, to avoid some of the delays that have plagued some recipients of funds under the UNDP administered programme. In order to avoid the gap in funding that has plagued so many NGOs that fully depend on the DFID/GFATM funds UNDP should pay implementing partners 6 months in advance rather than 3, with subsequent quarterly instalment (for M7-9 and subsequent quarters) payable after approval of quarterly progress and expenditure reports. UNDP should identify reasons for delays in delivery of supplies and ensure timely procurement and delivery of supplies to NGOs

5. UNDP should adhere to unit cost and agreed proportion of operational/staffing and programme costs when agreeing/signing programme extensions for 2007/2008. Any variations should be backed by a note on the reasons for the variations.

6. There should be more supporting / monitoring visits by UNDP staff so that NGOs receive adequate support and feedback in the field. The field officers, who may have less experience than many NGOs in the field, should be trained on how to

[§§] Areas of work identified during discussions with NGOs and Networks included Management (report and proposal writing, records / file management, financial management), Drug use (Harm reduction, rehabilitation, counseling to addicts, after-care, substitution therapy, etc), male sexual health (for MSM projects), sex work, community mobilization (for PLHA, MSM, IDU), counseling skills

conduct supervisory visits and how to provide support. The Colombo HIV/AIDS Practice team could provide the needed technical inputs.

7. UNDP should review reporting forms and adapt to project needs with participation from project NGOs. The use to which indicators will be put must be made clear to them and regular feedback to NGOs on their performance must be ensured. It will helpful to institutionalize the system of quarterly review, including sharing and learning, at district or regional levels and NCASC and DACCs can be invited to participate. There should be an independent outcome/impact assessment to inform programme planning and budgeting for 2007/8

8. UNDP programs dealing with social mobilization (RUPP) and promoting local governance (DLGSP) are successfully mainstreaming HIV/AIDS awareness and stigma reduction activities into development-related activities, with minimal input of financial resources. This, however, may depend greatly on the motivation and commitment of the District Development Advisor, the District Public Health Administrator and / or the Chair of the District Development Committee – the extent to which this is true could not be confirmed within the scope of the current consultancy. UNDP could ensure that HIV is always mainstreamed into the projects funded and managed by them.

9. UNDP, DFID and NCASC should ensure that District HIV/AIDS Coordination Committees (DACC) are given a formal role in endorsing or approving district-level interventions that are funded through the GFATM/AUSAID/DFID funded National Program. In the past, this has not happened. NGOs should be encouraged to work with DACC and field officers should be trained on how to facilitate the process. As a first step, UNDP should double-check whether the DACC and District Public Health Office (DPHO) have received copies of the approved project documents in their district. Strictly speaking this should be done by the National Centre for HIV/AIDS and STI Control (NCHASC), but in practice NCASC does not provide this information to the district level.

Annex 1: People consulted

Government

Nirakar Man Shreshta, Chief Specialist (Gazetted Special Class), MOH, GON
Rajendra Pant, Acting Director, NCASC
Ram Chandra Khanal, District Public Health Administrator, DPHO, Rupandehi District
Ram Hari Neupane, Programme Coordinator, District AIDS Coordination Committee, Chitwan
Mahon Marasini, member of the DACC for the Department of Planning
Mohamad Daud, District Public Health office

Dr Rauresh Basuyal, HIV program manager, Nepal Army

UN

Ghulam M. Isaczai, Deputy Resident Representative, UNDP
Aurorita Mendoza, UNAIDS Country Coordinator,
Sara Nyanti, HIV/AIDS Project Officer, UNICEF
Ivana Lohar, senior programme officer, acting chief, UNDP/PMU
Amaya Maw-Naing, Medical Officer, HIV/AIDS, WHO
Bina Pokharel, Senior Programme Co-ordinator, UNAIDS
Ram Krishna Pokharel, National Programme Manager, Decentralized Local Governance Support Programme, Lalitpur
Rojee Kattel, communication specialist, Decentralized Local Governance Support Programme, Lalitpur
Mr Parbati Pandel, Rural-Urban Partnership Programme, Lalitpur
Prabhu Raj Poudyal, strategic social advisor, Rural-Urban Partnership Programme, Lalitpur
Bandana Khaud, District Development Advisor, DLGSP project, Chitwan
Mira Khanal, social mobilization advisor, DLGSP project, Chitwan
Rudra Khadka, programme officer in Chitwan, UNICEF

Donors and technical assistance agencies

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NGO implementing partners of the DFID funded projects managed by UNDP

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Bishy Sharma, Richmond Fellowship

Bom Bahadur Rawal, Prerana, Basundhara
Deepa Joshi, Naya Goreto
Jeevan Kharel MRMG
Lata Ghimire, Help Nepal Network
Madhav Adhikari, SPARSHA Nepal
Mahesh Dev Bhattarai, GWP
Mukti Prasad Dhungana, Blue Diamond Society
Nisha Lama Karki, Richmond Fellowship
Norbert D'souza, St. Xavier's Social Service Centre
Pemu Budhthoki, Prerana, Basundhara
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Rajan Rana, LALS
Rajiv Kafle, Chair, Navkiran plus, Kathmandu
Rishi Raj Ojha, Chairman, Youth Power Nepal, Kathmandu
Roshan Verghese, Blue Diamond Society
Salina Tamanf, Blue Diamond Society
Sarmila Shrestha, WATCH
Ujjwal Karmacharya, SPARSHA Nepal

Gyanu Poudyal, President, NAMUNA Integrated Development Council, Bhirahawa
Dinesh Poudyal, Team Leader, NAMUNA Integrated Development Council, Bhirahawa
VCT counsellor, outreach worker, volunteer, field supervisor of NAMUNA Integrated Development Council, Bhirahawa

Dinesh Thape, field supervisor, Blue Diamond Society, Bhairahwa office
Hari Gurung (Sanu), supervisor of the drop-in centre, Blue Diamond Society, Bhairahwa office
Dr Santosh, medical doctor, Blue Diamond Society, Bhairahwa office
Outreach workers, lab technician, peer educators, finance officer of Blue Diamond Society, Bhaiwahwa office

Mr Basanta, President, Society Support Group
Prasad Malla, program coordinator, SAHARA drug user rehabilitation centre, Butwal
Mal Gozen, Finance officer, SAHARA drug user rehabilitation centre, Butwal
Bijaya Budha Magar, warden, SAHARA drug user rehabilitation centre, Butwal

Rajendra Bandhu Aryal, programme coordinator, Naulo Ghumti Nepal, Butwal
Dhaya Raj Bhattrai, programme officer, Naulo Ghumti Nepal, Butwal
One field worker and one counselor, Naulo Ghumti Nepal, Butwal

Shibu Giri, program coordinator, Nava Kiran Plus (PLHA Crisis Care), Butwal
Outreach worker, Nava Kiran Plus (PLHA Crisis Care), Butwal

Anoj Kumar Khadka, Team Leader, Bidyarthi Jagaran Manch, Hetuada
Ramesh Thapa, Medical supervisor, Navkiran Plus, hetuada
Purushottam Khanal, Field Supervisor, Community Welfare Centre: Hetuada
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Binaya K. Reybandhani, Project Coordinator, NFCC
Dr M.P. Shrestha, deputy executive director, NFCC

Min Bdr Kunwar, Chairperson, OCWAC-ACHHAM

J.C. Bhatta, Director, Nagarjun Development Community

P. Shah, Programme Director, MRING Nepal, KTM

Other NGO partners

Jagannatu Neupane, Nepali Red cross, Chitwan

Members of Adarsha – female community organization supported under the DLGSP project in Chitwan province

NGO networks

Ananda Pin, Recovering Nepal
Basanta Chettri, NAP+N
Jagdish Chandra Bhatta, NANGAN
Rishi Raj Ojha, Nepal HIV/AIDS Alliance
Sudin Sherchan, NAP+N

Annex 2: Documents studied

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Joint UN Programme on HIV/AIDS (2006-2011). UNAIDS Nepal, November 2006.

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UNDP HIV/AIDS Programme. PPT presentation by Ivana Lohar, Programme Manager a.i., January 2007

<u>For the UNDP part of this review (Annex 3)</u>

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NEP/03/003 – Rural-Urban Partnership Programme (RUPP) – project document, UNDP Nepal 2003

Decentralized Local Governance Support Programme – Mid-term review, revised draft 20 August 2006, UNDP Nepal

UNDP Corporate Strategy on HIV/AIDS, UNDP New York, 2006

Annex 3 – Thoughts on UNDP's role and mandate related to HIV/AIDS in Nepal

As a cosponsor of the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNDP has a specific and well-defined role in the overall response to HIV/AIDS of the United Nations system. All UNDP's work around HIV/AIDS is placed in the context of helping countries implement the 2001 Declaration of Commitment on HIV/AIDS and aimed at supporting countries in achieving the Millennium Development Goals (MDGs).

In 2005, the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (GTT) recommended several actions and strategies to strengthen the cohesion of national responses to HIV. Especially, the GTT found that UN cosponsors were often in competition with each other, and urged for a more strategic and specific division of tasks according to UN agencies' respective mandates and according to each cosponsor's specific strengths. The UNAIDS Cosponsors and Secretariat adopted these recommendations and agreed on a division of labour. Under this division, UNDP is the lead organization for addressing HIV and development, governance, mainstreaming, human rights and gender.

As the largest development agency in the world, UNDP is strategically placed to provide comprehensive support to countries in addressing the development challenges and impacts of the AIDS epidemic. Working through its network of 166 country offices, UNDP's response strategy focuses on three services that are complementary and mutually reinforcing: (i) HIV/AIDS and Human Development; (ii) Governance of HIV/AIDS Responses; and (iii) HIV/AIDS, Human Rights and Gender (Corporate Strategy on HIV/AIDS, UNDP 2006).

UNDP's Three Main Strategic Thrusts:

- Addressing the critical nexus between HIV and human development through mainstreaming HIV into development plans, promoting enabling macroeconomic policy options for sustained financing of AIDS responses, and building capacity for increased access to AIDS medicines;
- Strengthening the capacity of national authorities to more effectively govern the AIDS response, and supporting harmonization and alignment of UN system and donor support to national strategies and programmes;
- Promoting human rights and gender equality to reduce vulnerability to HIV, strengthening involvement of people living with HIV in AIDS responses, and addressing stigma and discrimination against people living with and affected by HIV.

Source: Corporate Strategy on HIV/AIDS, UNDP 2006

Mainstreaming of HIV/AIDS in development

UNDP Nepal has mainstreamed HIV awareness and stigma reduction messages and activities into two of its large development programs in Nepal. The Rural Urban Partnership Programme (RUPP) started in 2004 and aims to secure the right to sustainable livelihoods of rural and urban poor and to mitigate the causes of social conflict in Nepal, using four main activities: a) social mobilization, b) small enterprise development, c) strengthening urban and rural linkages and d) improving public service delivery to the poor. HIV/AIDS is not mentioned in the project document, but apparently some project sites have taken up the issue, either as a means for social mobilization or promoting sustainable livelihoods. The consultant visited a RUPP site in Butwal in Rupandehi District, where Mr Parbati Pandel and other staff supported through the programme appeared to have a personal interest in HIV/AIDS, strongly supported by the executive officer of Butwal Municipality. The project arranged for regular coordination meetings with NGOs working in Butwal Municipality, which was well appreciated by these NGOs. HIV/AIDS was included as an integral part of the District Development Plan (which was developed by the DDC in Bhairawa), and a budget had been set aside for activities within this plan, including the provision of soft loans to two people living with HIV/AIDS in order to help them generate income, coordination activities with NGOs and general awareness raising activities with the population, as part of which advocacy and awareness activities were undertaken during World AIDS Day, Condom Day and International Women's Day. Red ribbons had been distributed to all households in Butwal for World AIDS Day, and a 'psycho-yogic approach' had been promoted to increase the wellbeing for PLHA. The group mentioned that PLHA have to travel far (to Kathmandu) in order to access ARV treatment, and they urged UNDP to conduct advocacy at the central level to ensure more access to medicines for PLHA.

The Decentralized Local Governance Support Programme (DLGSP) aims to enhance effective participation of people in governance at the village and district level, ensuring improved access to socio-economic services by Dalits, disadvantaged groups (including women). Social mobilization activities include the establishment of (non-registered) community groups, capacity building of these groups as well as local bodies tasked with providing services to the poor. Like RUPP, it links and supports the implementation of the Government's Tenth Plan/Poverty Reduction Strategy Paper of reducing poverty, including a) improving the quality and availability of economic services and infrastructure for rural communities, b) ensuring social and economic inclusion of the poor and vulnerable, and c) the pursuit of good governance to improve service delivery efficiency, accountability and transparency at the local level.

In contrast to RUPP, where HIV earmarked funds were removed from the funds in 2003, DLGSP has set aside a very small budget for HIV related activities: 49.758 US$, mainly for orientation trainings for local bodies and the production of training and awareness raising materials; this amounts to 0.4% of the total programme budget. The consultant had a meeting with the District AIDS Coordination Committee in Bhairawa, which meets every two weeks and has developed a 2006-2008 District HIV/AIDS work plan with involvement of 39 different stakeholders (mostly NGOs), and the DCC has incorporated HIV/AIDS in the District Development Plan (See above). The DACC would welcome limited financial support for secretarial functions.

The consultant further visited a Community Organization for women in a village where HIV awareness activities had been held; the main purpose of the organization was saving and micro-finance, and there were meetings twice a month. The DLGSP project staff in the position of 'social mobilizer' said that she would refer women to VCT centres or other health care facilities if needed. The group tried to address HIV during its meetings, including stigma and discrimination of PLHA, of which there were none in the village. The group mentioned that they would like to have more in-depth knowledge about HIV/AIDS, and that there was a lack of IEC materials, especially for the less or illiterate.

The advantage of mainstreaming HIV into development programs is obvious. As UNDP's global strategy states, 'mainstreaming HIV into national development planning processes and poverty reduction strategies is critical to ensuring an effective multi-sector and multi-stakeholder response. To address the multiple dimensions of the AIDS epidemic HIV responses must be implemented across sectors, institutions and decentralized programmes' (UNDP 2006). But at the local level the advantage becomes a bit less clear. From an epidemiological perspective, teaching married women about HIV/AIDS is a waste of resources, since the only risk behaviour they are likely to engage in is having unprotected sex with their husbands, over which they have little control.

The problems that come with promoting mainstreaming of HIV into development responses without budget attached to it are:

1. As the mid-term review of the DLGDP project mentioned, mainstreaming invites a tendency to overload a program with issues (i.e. gender, environmentalism, safe motherhood, human rights, child rights, women's rights, literacy, the right to education etc), which may detract from its original objectives: i.e. to reduce poverty by means of social mobilization. Which of the issues to include may depend more on the personal interest of project staff than on community needs.
2. It is unlikely that serious monitoring and evaluation of HIV related work occurs if there are no budget lines related to it; both the donor and the implementer may see it as a secondary issue;
3. Whether HIV activities actually happen or not may well solely depend on the motivation and enthusiasm of individual program staff or counterparts, as was obviously the case in Butwal Municipality
4. Finally, from an epidemiological viewpoint it appears that development projects aimed at rural poor reach mainly people who are least likely to engage in risk behaviours for HIV/AIDS. Therefore the efforts spent on educating rural poor may be better used elsewhere.

Mainstreaming at the national level remains important in Nepal, where the national response has been characterized by a lack of non-health sector involvement – but at the district and village level it should be conducted with care, based on expressed community needs and based on epidemiological sense.

Strengthening the capacity of national entities

A second strategic thrust of UNDP's mandate is to strengthen national entities to respond to HIV/AIDS. In this field in Nepal, UNDP has been involved in the development of the National Strategic Framework 2006-2011 as well as a recently completed National M&E Framework.

By being first MSA and then Principal Recipient for the GFATM grant (including significant DFID and AUSAID support), UNDP is in effect fulfilling roles that under normal circumstances would be fulfilled by the Government itself. As UNDP itself admits, this is not a desirable situation and UNDP has often declared it is ready to hand over the management of the current programme to a national entity. Problem is that the current National Center for AIDS and STI Control is widely judged to have insufficient capacity to run the program, and a new entity that is advocated by some donors (most notably World Bank and UNAIDS) will not likely be established in time.

UNDP has, however, not been closely involved in discussions and advocacy with the Government to either strengthen NCASC or to create this semi-autonomous entity; it has not even taken an official position on this issue.

It is recommended that UNDP make up its mind about which 'exit strategy' to promote with the Government. An initial idea to consider – to show its commitment to hand over, and to urge the Government to make a move – would be to move the PMU to the NCASC or MOHP rather than being based at the UN compound. This may increase the ownership of the programme among Government staff.

An important issue to advocate for is the issue of salary supplements. This consultant believes that the Government entity running the program – whether it is NCASC or a new body – will never be able to attract motivated or competent staff if it is bound to hire following Government salary scales. If this issue is not settled, the creation of a new Government body for HIV/AIDS will be futile. Other strategies to attract and keep qualified staff are to provide education / training in exchange for the commitment to keep employed at the Government for a number of years.

Promoting human rights and gender equality

Gender and human rights are integral parts of the projects described above – i.e. RUPP and DLGSP actively address gender issues at the community level, helping in particular women organize themselves and finding a voice on issues important to them. The focus on improved governance, with an implicit anti-corruption view, as well as a focus on minority rights, also improves human rights for communities most in need. In these development projects, it could be said that gender, human rights and HIV/AIDS are all mainstreamed.

In terms of human rights, UNDP should consider taking advocacy with the central Government more seriously. Issues like trafficking of women and children, the criminalization of drug users and the continued criminalization of male to male sexuality in Nepal should be solved in order to create an enabling environment for development – as well as HIV prevention and care projects in Nepal.

(Note: This annex was written by Jan W de Lind van Wijngaarden without involvement of the other team members)

Annex 4 Safe and Effective Development in Conflict

This annex uses the DFID mandatory framework to assess application of SEDC

- What SEDC analysis has been done since the last report*? (this may be a formal analysis or more general/routine use of the approach in decision making)*

This was the first HIV/AIDS report for DFID.

- If this was a formal analysis - what triggered it*?*

There was no formal analysis – SEDC principles in practise were explored during the review

- If this was a more general use of the approach in routine decision making, what parts (tools?) of the SEDC approach were used and how?

SEDC as a package of tools was not used by UNDP

- What was the result of the analysis and what changes were made?

NA

- What was the impact of these changes?

NA

- Were any lessons learnt?

UNDP formal training in safety or development practice

The UNDP projects have been running for a maximum of a year and many for even less: some visited only commenced operations since Jana Andolan.

UNDP did not provide any staff/assets conflict related training or training or orientation on good development practice in conflict to the partners' pre project commencement. It appears that UNDP did not appraise the proposals from this dynamic. Organisations were expected to be able to ensure safety of staff and implement in a conflict-sensitive manner.

However, during implementation PP Pradhan and Co assessed safety of assets and staff as part of undertaking an assessment of financial and systems management (required by the GFATM).

ODC assessed performance (against agreed deliverables) in mid 2006 – but not development sensitive practice.

UNDP report that partners occasionally reported conflict related delays. These were related to local context issues and not specific to their operation. One partner was suspended due to Maoist threats and UNDP asked them to present evidence that they were neutral.

In general terms it is well known that conflict situations impact the AIDS epidemic and its prevention and control measures. Vulnerabilities of populations, especially the marginalised ones increase and prevention and treatment services are disrupted. In relation to this programme, there were some reports by some partners of some disruptions. UNDP and their partners need to have a fall back plan to provide services during disturbances.

The new context and its influence

Partners demonstrated how their approach to influencing many community members had been successful and how they are now well integrated into their communities. There are still challenges in this but there is clear evidence of increasing acceptability as a result of effective advocacy.

The new context appears to not have significantly influenced the operating environment. The Maoist policy position vis a vie those groups in society whose behaviour places them at higher risk of HIV, remains unclear. A few partners reported success is positively influencing the Maoist views in injecting drug use. Elected representatives could question the allocation of resources to marginalised groups and demand more equitable sharing of resources for prevention. Some communities have developed plans to advocate with the representatives to be elected in the coming general election

UN management

Partners informed the review team that being under the UN umbrella was a barrier to Maoist intervention. They felt a great deal more comfortable with UNDP managed funds than if funds were received from some donors.

The perception by partners that programme design favoured established organisations, mostly concentrated in the Kathmandu region, is a concern. So is the unwillingness to engage decentralised decision making structures in managing the programme.

Inclusion

The UNDP programme is targeting a selection of high risk behaviour groups. This is being done well. Within those groups, there was no evidence of exclusion. The partners were well able to demonstrate the ethnic composition of the groups' membership and explain how this matches perceived need. Most partners had mechanisms in place to reduce (or exempt) any service costs for the poor. However the over representation of higher socio economic groups in managing programmes that deal with an epidemics concentrated in lower economic rural groups have raised some concern.